Office for Citizens with Developmental Disabilities
PASRR NOTICE OF DETERMINATION

Placement/Services Decision

Name: _____ **DOB:** _____

Address: _____

_____

SS#: _____ **Medicaid #:** _____

Individual meets State law criteria for mental retardation or other developmental disability:

____ Yes: OCDD Statement of Approval (SOA) was issued on _____

____ No: OCDD Statement of Denial (SOD) was issued on _____

If no, OCDD to discontinue PASRR, sign at bottom and return to the Office of Aging and Adult Services for placement decision.

Nursing Home Placement is:

____ Needed

____ Not Needed

Nursing Home Placement Plus Services of Lesser Intensity Needed:

____ No

____ Yes

If yes, list recommended services: _____

_____

_____

_____

Nursing Home Placement Plus Specialized Services Needed:

____ No

____ Yes

If yes, list recommended specialized services: _____

_____

_____

_____

_____

Placement Options that are available to the person consistent with the determination of the following alternative (select one):

____ a. Can be admitted to a Nursing Facility

____ b. Cannot be admitted to a Nursing Facility

____ c. Can be considered appropriate for continued placement in a Nursing Facility

____ d. May choose to remain in the Nursing Facility even though the placement would otherwise be inappropriate (Note: Only for those applicants in need of specialized services and who have resided in the NF for more than 36 months)

____ e. Cannot be considered appropriate for continued placement in a Nursing Facility and must be discharged (short-term resident) (Note: Only for those applicants in need of specialized services who have resided in the NF for less than 36 months)

____ f. Cannot be considered appropriate for continued placement in a Nursing Facility and must be discharged (short or long-term) (Note: Only for those applicants who are not in need of specialized services, regardless of length of residence in the NF)

_____

If placement option "d" is chosen: Indicate how, when and by whom information about various placement options available will be explained to applicant.

_____

_____

_____

If placement options "e" or "f" is chosen: Indicate how, when and by whom information concerning discharge arrangements and appeal rights will be explained to the applicant.

_____

_____

_____

_____

Information Concerning OCDD Regional Office/District/Authority Making the Placement Decision:

Signature of OCDD Regional Office/District/Authority Staff _____

Date of Decision: _____

Address of OCDD Regional Office/District/Authority

_____

_____

Region #/District/Authority _____

Telephone Number _____ Fax Number _____

FAIR HEARING RIGHTS: A request for a hearing may be made in writing to the Department of Health and Hospitals, Bureau of Appeals, P.O. Box 4183, Baton Rouge, LA 70821-4183. The request must be made within 30 days of receiving this determination.

Original: OAAS Regional Office
Copies: OCDD Central Office
OCDD Regional Office/District/Authority

REQUEST FOR APPEALS HEARING

___ **I disagree with this decision and wish to appeal by requesting a hearing. (Must mail back within 30 calendar days of the receipt of this Notice).** Mail this to:

Mr. Ivory Trent

DHH Bureau of Appeals

P.O. Box 4183

Baton Rouge, LA 70821-8773

(225) 342 – 0263

(225) 342 – 8773 (fax)

INCLUDE A COPY OF THE ATTACHED LETTER WITH YOUR MAILING SO THAT THE BUREAU OF APPEALS WILL KNOW TO WHOM THIS REQUEST REFERS.

KEEP A COPY FOR YOURSELF.

PRINT NAME:_____

SOCIAL SECURITY NUMBER_____

_____ _____

Signature Date

If you are a parent of a minor child, or have legal authority to act for the person, and are filing this appeal on his or her behalf, print his or her name above.